Pain, the 5th Vital Sign:
Evaluating compliance in documenting pain assessment after making pain assessment part of vital signs.

Background:

There is a high prevalence of acute and chronic pain in hospitals in the UK and worldwide (Van den Beuken et. al. 2016, Gregory and McGowan, 2016). The reasons for this high prevalence are multiple, however failure to assess pain has been identified as one of the main causes. Pain assessment can be defined as the cornerstone of pain management because it enables adequate prescription of analgesics and is essential to evaluate the effectiveness of the pain management planned.

The introduction of Electronic Patient Record (EPR) system in the Trust in 2015 resulted in a dramatic reduction in compliance of pain assessment documentation: from 92% on paper based documentation to 12% on the new electronic system in 2016. The pain assessment section on EPR was located on a different section to the vital signs; following this decline in pain score documentation, pain assessment was added alongside vital sign observations making pain the 5th vital sign.

Aim and Objectives:

The expected Trust standards, as per Pain Service Guidelines, is that 100% of patients have their pain assessed and scores documented along with the other vital signs, and a minimum of once a day.

The Trust's Acute Pain Service audits the documentation of pain scores yearly. The aim of this audit was to identify compliance in documentation of pain assessment and evaluate the effectiveness of changes made to EPR.

Methods:

A snap shot audit was performed of a randomly selected 24 hours period. All adult in-patients electronic records where reviewed. Patients in paediatrics, ITU and A&E were excluded. Comparison was made with previous years' pain assessment documentation audit.

Main Results:

241 patients were identified during the 24 hour period; 84% had their pain assessment documented at least once during that period, however only one patient had a pain assessment on movement documented.

This represents an increase of 72% in the documentation of pain scores compared with 2016. This can be attributed to changes implemented on EPR as well as the provision of training on pain assessment and documentation to Healthcare Assistants and Registered Nurses. Although further training and education is required to improve pain assessment at rest and on movement there has been significant progress.

Conclusion:

The results show a significant improvement in pain score documentation, with most patients having their pain assessed and recorded within the last 24 hours, however pain was only assessed at rest; this identifies the need for further pain education and training within the Trust. This audit shows the levels of pain score documentation remain lower than before the introduction of EPR, suggesting additional changes could be implemented on this system to facilitate documentation further.